

RESOURCE MATERIALS

IN THIS SECTION

- A. Community Benefits Laws, Regulations, and Guidelines 94
- B. Handling the Tough Questions 95
- C. Free-Care Safety Net Fact Sheet. 102
- D. Organizing Opportunities and Helpful Terms. 107
- E. Model Act: The Healthcare Institution Responsibility Act 111
- F. Excerpts from the Catholic Health Association Social
Accountability Budget 119
- G. Other Helpful Materials Available on Community Benefits 122

The information in this section is supplemental to the materials found in the preceding pages of the manual and can be used for reference. As you begin to design your own community benefits campaign, these fact sheets and tables will be useful.

A. Community Benefits Laws, Regulations, and Guidelines*

State	Citation	Governs
California	Cal. Health & Safety Code § 127340, <i>et seq.</i>	Private nonprofit acute-care hospitals
Connecticut	Public Act. No. 00-57 2000 Substitute House Bill No. 5292	Hospitals and managed care organizations
Georgia	Ga. Code Ann. §§ 14-3-305, 31-7-90.1	Nonprofit hospitals operated by hospital authorities (a public body)
Idaho	1999 Idaho Sess. Laws 126 Idaho Code § 63-602D	Tax exempt nonprofit hospitals
Indiana	Ind. Code § 16-21-9-1, <i>et seq.</i>	Nonprofit hospitals
Massachusetts	Attorney General’s Community Benefit Guidelines for Nonprofit Acute Care Hospitals, June 1994 (reissued January 2000); Attorney General’s Community Benefit Guidelines for Health Maintenance Organizations, February 1996 (reissued January 2000).	Nonprofit acute care hospitals; HMOs
Minnesota	Minn. Stat. § 144.698 Minn. Stat. § 62Q.07	Acute care institutions and outpatient surgical centers, health insurers, including HMOs
New Hampshire	1999 N.H. Laws 0924 N.H. Rev. Stat. § 7.32-c, <i>et seq.</i>	Healthcare charitable trusts (nonprofit hospitals, insurers [BCBS is excluded], and HMOs)
New York	N.Y. Pub. Health Law § 2803-1	Nonprofit general hospitals
Pennsylvania	10 Pa. Cons. Stat. § 371, <i>et seq.</i>	Institutions of purely public charity
Rhode Island	R.I. Gen. Laws § 23-17-43	Hospitals (statewide community standard for provision of charity care)
Texas	Tex. Health & Safety Code Ann. § 311.042, <i>et seq.</i>	Nonprofit hospitals
Utah	Nonprofit Hospital and Nursing Home Charitable Property Tax Exemption Standards (December 18, 1990), Utah State Tax Commission	Nonprofit hospitals and nursing homes
West Virginia	W.Va. Code State R. tit. 110, § 24.1	Tax exemption of nonprofit hospitals

* As of the printing of this manual, 14 states had passed laws, regulations, or guidelines that related to community benefits.

B. Handling the Tough Questions

If your group takes on a community benefits effort, there may be critics. Institutions, legislators, regulators, providers, the media, and other people within your community may be openly critical of your efforts. You may get tough questions about why institutions should provide community benefits at all. This section of the workbook anticipates these tough questions and provides you with “sound bites,” or quick answers, as well as more detailed explanations helpful to community leaders speaking publicly. It may also be potentially useful for the sympathetic institutional insider, legislator, or regulator who wants to champion community benefits within an institution or from a regulatory or legislative framework.

1. Question: For-profit healthcare institutions pay taxes; why should they also provide community benefits?

Quick Answer: Health care is different from other for-profit industries because it is so basic and essential for all people: Hospitals are required to treat people in emergency situations regardless of ability to pay.⁷⁰ Community benefits applies this “social good” view of health care to nonemergency situations because we believe that all people should have basic access to “health” care (as well as sick care). Besides, other for-profit corporations have recognized their obligations as corporate citizens in our communities. Banks, classic bottom-line institutions, have a 50-state community obligation, so why shouldn’t healthcare institutions?⁷¹

Further Discussion: For-profit healthcare institutions should also have a community interest obligation to the public because they increasingly are dominant players in local healthcare markets. Their strong position in local markets is creating an uneven playing field. While they have great resources, for-profits service a smaller percent of the at-risk population. The effect is either to increase responsibility of public and nonprofit institutions or to leave more people unserved. From a public policy perspective it makes sense to require for-profit institutions to provide free care and community benefits to the communities they serve. However, there may be a different standard for community obligation between tax-exempt nonprofits and tax-paying for-profits.

Additionally, many for-profit institutions were once nonprofit. In many of these cases, state regulators and legislators have required that these converted institutions provide community benefits at the same levels as did their predecessor nonprofits as a condition for approving the conversion. These conditions have been required through legislation, as a condition of regulatory approval of the transaction. They also have been obtained via private agreement between the community, the institution, and sometimes the regulator. Community activism and vigilance are what have led regulators and legislators to impose these conditions on for-profit healthcare institutions. However, it is important to note that community benefits commitments can be gained in

70. 42 United States Code § 1395dd.

71. See page 15 for a discussion of the Community Reinvestment Act (12 U.S.C. § 2901, *et. seq.*) which requires banks to demonstrate that they are serving their communities, not just their customers.

RESOURCE MATERIALS

policymaking arenas other than the legislative. Private agreements have the potential to be very effective over the long term, and conversion transactions are tremendous opportunities for advancing community benefits because community and regulatory leverage is so strong. Many for-profits see community benefits in this context as a cost of getting the deal done.

2. Question: We're a nonprofit hospital, and we already provide more free care and treat more Medicaid patients than any other hospital in the community. We can't afford to do any more.

Quick Answer: Collaborating with community leaders in a community benefit process does not necessarily cost more for the institution. In fact, in the long run it could cost less, if health status among indigent patients is improved and patients seek care before they become severely ill, when care is more expensive. For example, shifting resources into preventative programs may be less costly than treating very sick people in the emergency room. It's not just a question of how much free care your institution is providing, but a question of what type of care and the process by which community benefit priorities are chosen. Institutional partnership with the community can result in greater and more sustainable community health improvement with the same amount of resources.

Further Discussion: A community benefits program should be based on priorities determined through a collaborative institution-community planning process. Such a process takes advantage of institutional healthcare knowledge and the expertise and experiences of community leaders to solve community problems. Good communication will ensure that all the assets of the community can be dedicated to improving health status. Institutions providing more resources than other hospitals and health institutions in the area to solve community health problems can work together to create a model for collaboration and to set a standard for results.

3. Question: We already make charitable donations to a number of causes. Isn't that enough?

Quick Answer: Are these donations made to charities that target priority community health needs? How are these charities chosen?

Further Discussion: It depends. The charities to which an institution makes donations may not serve the community's needs and concerns. While it is admirable to make charitable donations, community benefits should be determined through a process that involves the community. For example, your institution might not be meeting community needs if your community has a very large teen pregnancy problem, and you sponsor a road race in another city that supports breast cancer research.

4. Question: Our employees participate in many community activities — mentoring programs, domestic abuse counseling, donations to the United Way. Aren't these community benefits?

Quick Answer: All the institution did was hire good people! Plus, individual generosity does not equal an institutional commitment to community benefits.

Further Discussion: Employee volunteer activities could be considered a community benefit if the employees are given paid time off to participate in activities that address community-identified health needs or if such activities are considered to be a part of their jobs. Otherwise it is inappropriate to claim the volunteer work or charitable giving of employees as an institutional community benefit.

5. Question: We're a teaching institution that trains doctors, conducts research, and develops state of the art medical technology — all of which work to make sick people better faster: that is a community benefit.

Quick Answer: If you are wealthy and/or fully insured, you benefit from highly trained specialists and cutting edge technology. However, such “benefits” are unlikely to reach those most in need. An uninsured or underinsured person or family likely has trouble getting even the most basic care. Research and technological developments are of “benefit” to society. But the definition of community benefit is more specific than the claim that merely operating and existing is of benefit to the community and therefore a community benefit.

Further Discussion: Is the focus of the teaching institution in sync with the needs of the community? For example, some teaching institutions will train more specialists than internists, even though their surrounding community may have a shortage of primary care physicians. Does the institution pay attention to cultivating doctors and medical students who are committed to the local community? Or does it train physicians who then take their knowledge elsewhere? Does the institution cultivate medical students who reflect the cultural diversity of the community? If the institution is a hospital, what is its community benefit activity outside of medical education?

6. Question: Community benefits are for hospitals; we're an insurer and we don't provide care.

Quick Answer: The growing and unmet health needs that exist in our communities are serious. In today's health system, where over 85 percent of the enrolled workforce is in managed care,⁷² we should not be relying solely on hospital resources to fulfill these needs. In order to solve the complex problems in health care, all the players need to participate, and insurers and HMOs are definitely players in today's health system.

⁷² Department of Health and Human Services, *Highlights National Expenditures, 1997* (last modified October 30, 1998) <http://www.hcfa.gov/stats/nhe-oact/hilites.htm>.

Further Discussion: Insurers and HMOs often possess tremendous financial resources and power in our communities. They are changing the incentives and dynamics in local health care delivery systems. As the health system evolves and the lines between insurers and providers continue to be blurred (is an HMO an insurer or a provider or both?), traditional ideas about community benefits must also change. In fact, shifts in the industry are the genesis for changes in the way policymakers and community leaders are viewing community benefits. Community benefits are no longer the sole province of nonprofit hospitals. Whether nonprofit or for-profit, there are many other types of institutions that can and should be held responsible for community benefits obligations.

7. Question: As the state’s largest insurer, the “community” we serve encompasses the entire state. How can we provide community benefits to such a vast constituency?

Quick Answer: You don’t need to provide community benefits to everyone. You should choose a vulnerable group and work with that group to identify its priority issues. For example, you could target the elderly and provide prescription drugs or discounts on drugs for those whose insurance does not cover prescription drugs.

Further Discussion: It is better to choose a discrete group for several reasons. You will be able to identify and convene members of that group so that you can get a grounded sense of its priority issues. You will also be able to consult directly with them on the best way to address any issue, given the particular circumstances faced by people in that group. Third, targeting resources will make it easier to understand the effect of community benefits programming and more likely that problems within the program will be identified and solved through consumer feedback.

8. Question: We’re considered “the insurer of last resort.” Isn’t that a community benefit?

Quick Answer: It is a legitimate piece of a community benefit effort, but after passage of the federal Health Insurance Portability and Accountability Act (HIPAA, also known as “Kennedy-Kassebaum”) and the various state laws that followed it, the need for an “insurer of last resort” has been overshadowed by other pressing health needs.⁷³ Moreover, insurers and HMOs are best positioned to respond to the lack of preventative care for indigent patients, transitional insurance coverage for welfare-to-work families, and well-child programs.

73. HIPAA mandates that insurers offer and renew policies without regard to the health of the individual, the members of the group, or their dependents. It also changes preexisting condition law so that a person does not lose coverage for a preexisting condition just because he or she changes to a new policy. For more information, see *State and Federal Insurance Reforms for Individuals and Small Groups* (States of Health, September 1997), available from Community Catalyst.

RESOURCE MATERIALS

Further Discussion: The rationale here is the same as it is for question 6. All stakeholders in the health care system, including consumers, insurers, and hospitals, need to participate and collaborate in problem solving and evaluation in order to improve delivery of health care. Keep in mind that “insurer-of-last-resort” status is an incomplete and inadequate measure to address unmet health needs especially for the over forty-four million uninsured people who can’t afford what is often expensive nongroup health insurance.

9. Question: We know the problems in the community; we don’t need to consult with the community. Besides, our board consists almost entirely of community leaders.

Quick Answer: Would you launch a new product without doing market research? Your board consists of community/civic leaders, but can and should they speak for the uninsured and underserved members of the community who should be the focus of any community benefits effort?

Further Discussion: Institutional executives, administrators, and board members who make decisions about health care resources are often outstanding civic and business leaders. In their decisionmaking they may take “community” into account, but if they are unfamiliar or isolated from vulnerable populations, then their idea of community is not complete. The very people meant to benefit from “community benefits” are not represented in the decisionmaking and resource allocation process.

Currently over forty-four million people are uninsured in this country. An even larger and growing number of people are at risk for poor health status because of a complex mix of factors such as lack of transportation, education, or interpreters or complex enrollment procedures, discriminatory treatment, and cultural differences.⁷⁴ Identifying the exact mix of barriers and issues that particular people face in trying to access quality health care requires feedback from the very people that face those barriers every day. People who live the situation bring invaluable information not only about the barriers, but about solutions that fit their particular circumstances and existing community infrastructure and resources. They should be involved as partners who are recognized for the important insights they bring to the table about community health needs and possible solutions. Institutions ready to dedicate dollars to a community benefit program should think of such a process in terms of market research and as a means to increase the effectiveness and efficiency of their community benefits products.

⁷⁴ See Robert Kuttner, “The American Health Care System: Health Insurance Coverage,” *New England Journal of Medicine* 340 (January 14, 1999).

10. Question: We provide health care. That's a community benefit.

Quick Answer: While we provide care to those who have insurance, there remain over forty-four million people without insurance. No matter what, we pay for their care. Community benefits are efforts to shift institutional resources into tailored strategies to improve the health of the uninsured and vulnerable. We can either pay to keep people healthy or we can pay for sick people and their care.

Further Discussion: There is an overwhelming need for improvement in the way that uninsured and vulnerable populations access health care. The support, expertise, and cooperation of all healthcare institutions is needed.

11. Question: We have a fiduciary responsibility to run a financially viable institution, and keeping this institution viable is critical to the community.

Quick Answer: We don't think we have to threaten or harm the financial health of any institution in order to make the community healthier. Institutions should not view community benefits efforts as a threat to their financial stability, particularly before any discussions have taken place. The community position is not black and white. We want to look at the issues and work together to craft solutions that will work for our institutions and for us as consumers over the long term. We all have to balance the checkbook!

Further Discussion: The financial viability of the healthcare institution is important to the community. And the support of the community is critical to its long-term viability. A commitment to collaboration and community benefits planning does not necessarily require allocating more resources. Perhaps the institution is spending resources in an ineffective or untargeted way. For example, one community benefits campaign identified the use of outreach workers as an important tool to improve access to primary care in the community. The community may prioritize a part-time outreach worker over some other program currently offered by the institution. The end result can be a simple shifting of resources.

On the other hand institutions may claim they are suffering financially, when in fact they are not. (See page 63 for examples of community groups working to define the financial capacity of local hospitals.)

12. Question: Community benefits are not enough to solve the very serious problems that plague our health system. We should focus on other issues.

Quick Answer: In a situation that is so complex with problems so large, is there any better place to begin than by building dialogue among the various players and participants? Besides that, unreimbursed care and other services are the only available option for over forty-four million uninsured people. Isn't that enough of a reason?

RESOURCE MATERIALS

Further Discussion: Though not a panacea for all community health woes, improving community benefits can establish important building blocks to healthier individuals and communities. When people hear the term community benefits, they probably think of health services for traditionally disenfranchised populations. But, the concept transcends the service component. Ideally, community benefits also means strengthening strained or disconnected institution–community relations. It means strong communities engaging in collaborative problem-solving with institutions to achieve both short-term goals (e.g., better free-care policies and removing all of the health access barriers described earlier) and long-term goals (e.g., expansion of coverage and other systemic health reforms). Of course, this is the ideal. But, communities that engage in community benefits campaigns are likely to see health institutions that have become more familiar with the needs of vulnerable populations as well as more open to community participation. Both this familiarity and openness are necessary ingredients to ensure that any reform actually translates into greater access and better quality health care.

C. Free-Care Safety Net Fact Sheet⁷⁵

WHAT IS FREE CARE?

Free care is care provided by a hospital for which it does not expect to be paid.⁷⁶ Hospitals may provide free care to people who show they cannot afford to pay for their care. Some hospitals also provide services at a discount to patients who are able to pay some, but not all, of the cost of their care. These discounted services are also considered free care. Most hospitals require that in order to be eligible for free care, a patient's income must be under a certain defined level.

ARE HOSPITALS OBLIGATED TO PROVIDE FREE SERVICES?

There are laws and legal obligations that require hospitals to provide free services to those in need. However, these laws are often quite vague and limited. Although they do provide a base for valuable community care, they often lack specific requirements as to how or how much free care hospitals must provide.

For example, nonprofit hospitals are classified as charities and receive tax exemptions, and therefore have some obligation to provide services and other benefits to the community. Often this obligation is met in part by providing some amount of free or reduced-cost care. Additionally, some state laws require hospitals, nonprofit or for-profit, to provide services to those who can't afford to pay. And hospitals with emergency rooms are obligated under federal law to provide at least emergency services to those in crisis regardless of their ability to pay.

Despite the critical importance of free care to the more than forty-two million uninsured people in this country, there are no standard federal free-care requirements and few clear state standards. Since there are so few standards, each hospital creates its own free-care policy. Because the laws do not require hospitals to provide certain levels, free care is different from hospital to hospital and access to health care for the uninsured varies from community to community.

IS IT EASY TO GET FREE CARE?

Despite the fact that free care is an important foundation of our healthcare safety net, it can sometimes be difficult to obtain. Since individual hospitals create their own free-care policies, problems can arise. For example:

- There may not be a standard process within a hospital. The hospital may give free care on a discretionary basis and make decisions on a case-by-case basis.
- Those in need of services may not even know that the hospital provides free care. Information about free care may not be given at the time of service. The hospital may not post signs or provide pamphlets explaining its free-care policy. If there are signs or pamphlets, they may be written in a language the patient does not understand or may explain the policy in a very complicated or intimidating way.

75. Additional copies of this Fact Sheet can be obtained by contacting The Access Project.

76. An overwhelming majority of states consider free care to be a community benefit. At least one state, Massachusetts, excludes it as a community benefit because there is a separate financing mechanism for free care.

RESOURCE MATERIALS

- The application itself may be difficult to read, complicated to complete, or written in a language the patient does not understand.
- The application process may be disrespectful, long, and complicated, and patients may receive bills in the meantime.
- Only certain services may be provided free. Patients could still be left with large bills even after receiving free care. For example, room and board may be covered but laboratory and doctor services often are not.
- Eligibility levels may be set excessively low. People who own a home or a car may be disqualified from receiving free care.
- Free-care patients may get different treatment or receive different priority from insured patients.

HOW DOES THIS CONFUSION AFFECT THE UNINSURED?

For people who are already in ill health, the effect can be devastating.

- Uninsured people may be intimidated or confused by the application process and therefore decide not to get the care they need, or delay getting it, making them sicker.
- Uninsured patients may try to pay hospital bills instead of getting needed medications, paying rent, or buying food.
- Patients unable to pay may be subject to stressful harassment from bill collectors.
- Because of unclear eligibility requirements, people who are actually eligible for free care may be denied free services.

WHAT SHOULD A GOOD FREE-CARE POLICY INCLUDE?

1. A written, board-approved policy that sets a clear and consistent standard for free-care eligibility.
2. Notice to the community that free care is available, including appropriate notice during the admitting process, notices throughout the hospital, and outreach to free-care-eligible populations in the community.
3. A simple and language-appropriate application including an explanation of the time frame and process for approval, the hospital and patient responsibility, if any, and all options available to the patient, including sliding scale fees or discounted fees based on ability to pay. The application should clearly state what the patient can expect and it should guarantee that the patient will not be billed until a free-care determination has been made.
4. A respectful and quick approval process including open communication between patient and institution.
5. Comprehensive health services including prescription drugs, laboratory services, doctor and specialist services, and X-rays.

HOW CAN COMMUNITY LEADERS TAKE FIRST STEPS TOWARD IMPROVING FREE CARE?

Community groups should learn about the free-care policies at their local hospitals. Community leaders should find out whether there are free-care laws or regulations in their state and what these laws require. An important first step would be to request the policy and an application directly from the hospital. The hospital response and the materials you receive will reveal a great deal about the fairness and effectiveness of the policy. Interviewing free-care patients is also important to understanding how the free-care process might be improved. Clinic providers and other primary care providers in the community will also provide valuable information and a slightly different perspective about unmet healthcare needs and the relationship of local hospitals to the community. The task is to identify problems as well as what is working.

WHAT ARE THE OPPORTUNITIES COMMUNITY LEADERS CAN USE TO RAISE THESE ISSUES?

The first step is to approach the hospital. Some institutions will be willing to discuss free care with community leaders and advocates and make changes to improve free-care policy. There are also many changes that are occurring today in the healthcare marketplace, such as mergers and nonprofit to for-profit conversions, new laws and regulations addressing hospital community benefits obligations, and the development of Medicaid managed-care networks. Many of these changes present opportunities for community groups to negotiate for more free care and better policies.

Holding Hospitals Accountable for Free Care in Your Community

In addition to looking at a hospital's free-care policy (i.e., how that hospital decides what free care to provide), there is also the question of how much free care the hospital provides, and whether that is sufficient.

Determining how much free care hospitals actually provide can be complicated but, it is important to understand in order to ensure that the community is being fully served. There are certain key concepts to understand when determining how much free care a hospital is providing and how much it should be providing.

FREE CARE, BAD DEBT, AND UNCOMPENSATED CARE

Key Definitions:

- **Free Care:** These are free services hospitals provide to patients who show that they cannot afford to pay for their care. Hospitals do not expect to be paid for these services.
- **Bad Debt:** These are the services hospitals provide for which they expect payment, but never receive it. Bad debt usually arises out of insurance companies or individual patients not paying bills.

RESOURCE MATERIALS

- **Uncompensated Care:** These are the services that hospitals provide but for which they do not receive full payment. The term includes free care and many categories of “unpaid care” including bills that insurance companies and individuals don’t pay. “Uncompensated care” may also include the difference between what the hospital receives for treating Medicare and Medicaid patients and what it usually receives for privately insured patients. Hospitals lump all these shortfalls together and call them uncompensated care.

WHAT IS THE DIFFERENCE BETWEEN BAD DEBT AND FREE CARE?

In reality, it may be difficult to see the difference between free care and bad debt from these very general definitions. The following two examples should help illustrate the difference.

- **Bad Debt:** An insured woman takes her baby to the emergency room with a high fever. The baby is treated and released. Because she didn’t get prior approval before going to the ER, her insurance company denies coverage and will not pay the hospital for the services. The hospital sends her the bill, but she does not pay it. The hospital assumes the loss.
- **Free Care:** An uninsured, single, twenty-five-year-old woman goes to the hospital with a broken arm. She applies for and receives free care because her income of six thousand dollars per year is below the eligibility level defined by the hospital or state.

WHY ARE THESE DIFFERENCES IMPORTANT TO THE COMMUNITY?

In order to hold a hospital accountable for providing free care, it’s important to get an accurate assessment of the free services it provides. Hospitals may talk about free care and uncompensated care as if they were the same. Since uncompensated care includes free care, bad debt, and often the Medicare and Medicaid “shortfall,” it is not an accurate assessment of how much free care the hospital is really providing to the community.

WHY IS IT IMPORTANT TO EXCLUDE BAD DEBT WHEN CALCULATING FREE CARE?

Not all services classified as bad debt are provided to those who are unable to pay. For example, when insurance companies refuse to pay the hospital bills of policy holders, it increases a hospital’s bad debt and benefits only the insurance companies. In these cases, patients are not receiving free care because they, or their employers, are paying insurance premiums. All industries have bad debt; it is simply a cost of doing business.

COSTS AND CHARGES

Key Definitions:

- **Cost:** This is the actual amount of money a hospital spends to provide each service.
- **Charge:** This is the full list price of a given hospital service. Many HMOs and insurance companies negotiate price discounts and do not actually pay full charges.

WHY IS IT IMPORTANT TO UNDERSTAND THE DIFFERENCE BETWEEN COSTS AND CHARGES?

When citing the amount of free care that they provide to the community, hospitals will often base calculations on the price that they charge instead of the actual cost of providing the service. In such instances, it can appear that the hospital is providing more free care than it actually does. Communities should ask hospitals to provide free-care calculations based on cost, not charges. If no cost-based information is available, using one-half of charges is a good approximation.

Even for uninsured and underinsured individuals who are not eligible for free care, the distinction between cost and charge is very important. Often, the uninsured and underinsured patient will pay the full retail price for a service while an insurance company can negotiate a discount. Thus, people with middle incomes who are uninsured or underinsured but are not eligible for free care end up paying the most for their healthcare.

Strong free-care policies together with appropriate accounting from your local hospital will ensure that eligible free-care recipients are not denied free care and that all available resources are dedicated to caring for those most vulnerable in our communities.

KEY QUESTIONS TO ASK ABOUT A HOSPITAL'S FREE-CARE POLICY

1. Is there a written policy available that sets clear standards for free-care eligibility?
2. Are the hospital's policies regarding free care widely available and easy to understand?
3. What are the exact free-care eligibility requirements? What is included in income calculations? For example, must people mortgage their home before they are eligible for free care?
4. Is there a partial free-care or sliding scale system based on a person's ability to pay?
5. What services are covered under the free-care policy—doctors' services? lab work? prescription drugs? Is every available effort made to provide comprehensive services as free care, and not just emergency care? Does the hospital have an on-site pharmacy and staff physicians who could provide free services?
6. Does the free-care application process put patients at ease? Is it a daunting or intimidating process? Are applicants treated with respect?
7. When is free-care eligibility determined—before or after services are provided? Are patients billed while they wait for an eligibility decision?
8. Is the measurement of "overall free care provided" based on the actual cost of goods and services provided, or is it based on the much higher price normally charged to an insured patient? Is the hospital counting bad debt as free care?

D. Organizing Opportunities and Helpful Terms

Organizing Opportunity	Regulatory Oversight	Relevant Laws	Important Information
Health Institution Restructuring (see page 62 for example)	Commissioner of Health; Commissioner of Insurance; Commissioner of Corporations; Attorney General	Conversion legislation; Certificate of need laws; Licensing and certificate of authority laws; Nonprofit corporation code; Corporation code	Articles of incorporation or bylaws; Corporation's financial statements for the past five years; Form A (for insurers and HMOs)
Community Examines Hospital Books, Issues Report (see page 63 for example)	Attorney General	Nonprofit corporation code; Tax code	Articles of incorporation or bylaws; Audited financial statements; Property assessments; IRS filings
Linking Neighborhoods and Constituencies for Power (see page 64 for example)	N/A	N/A	After groups have met and connected, they can determine the institution or issue to target and the corresponding important information.
Challenging Institutional Behavior (see page 65 for example)	Commissioner of Public Health; County or City Commissioners (if a public hospital)	Certificate of need laws; Licensing laws; Hill-Burton (if any requirements continue to exist); State free care requirements (may stand alone or may be found in other laws such as hospital regulations or conversion laws. Some hospitals may be required to perform a certain level of free care based on an earlier agreement).	For closing of services: Certificate of need application (if required in your state); For collection policies you should consult: <ul style="list-style-type: none"> • Institution's financial records for the past five years • Financial records of nearby hospitals for comparison purposes • Records at the local assessor's office to see who has had a lien placed against them by the institution. If there are many people with liens, it is an indication that the institution has poor collection practice.
Ensuring the Community's Leadership (see page 65 for example)	Department of Public Health; Department of Insurance; Attorney General	Although an institution may begin a community benefits effort on its own initiative, it is more likely that the impetus could come from any of the following sources: <ul style="list-style-type: none"> • Conversion legislation • Certificate of need laws • Licensing and certificate of authority law • Nonprofit corporation code • Corporation code 	<ul style="list-style-type: none"> • Articles of incorporation or bylaws • Audited financial statements • Property assessments • IRS filings • Financial records of nearby hospitals for comparison purposes
Community Benefit Laws (see page 67 for example)	Commissioner of Health; Commissioner of Insurance; Attorney General	Community Benefits Law; Certificate of Need Law; Conversion Law; Tax Law	Community Health Needs Assessment; Community Benefits Plan

RESOURCE MATERIALS

The grid on the previous page is designed to provide you with the necessary information to begin a community benefits campaign based on a number of “organizing opportunities.” After the opportunity, it lists the regulators involved, relevant laws, and other important information. A list of Helpful Terms explaining many of the terms in this grid follows. Each organizing opportunity corresponds to an example in the workbook as noted.

Helpful Terms

REGULATORS

- **Attorney general.** Nonprofit institutions are made up of charitable assets, and each state’s attorney general is responsible for monitoring charitable assets and ensuring that they are devoted to their original intended purpose. The attorney general must make sure the nonprofit charitable assets of the hospital, HMO, or insurer continue to be devoted to their original purposes (i.e., health care of the community).
- **Commissioner of corporations.** The commissioner of corporations must approve the articles of incorporation and bylaws of any new corporation (whether nonprofit or for-profit). However, in most states, the commissioner automatically approves articles of incorporation and bylaws as long as they are filed on time.
- **Commissioner of health.** The state commissioner of health is often charged with licensing hospitals and granting certificates of need, and as a result, is often required to approve transactions involving healthcare entities (mergers, conversions, sales).
- **Commissioner of insurance.** The state commissioner of insurance regulates insurers and HMOs by granting licenses (“certificates of authority”), and thus approves transactions involving HMOs and insurers.

RELEVANT LAWS

Community leaders who are beginning a community benefits campaign need to find avenues for public process (e.g., public hearings, public notification of transactions, and availability of documents for public inspection). Certain laws that are pertinent to the healthcare industry contain these provisions. Below is a list and description of laws that may contain public process provisions. Because laws vary from state to state, it is important that you become familiar with your state’s laws.

- **Certificate of need laws.** These laws require hospitals to obtain a certificate or permit from the state department of health prior to making a significant expenditure or change to the hospital, such as a new heart transplant service or a change in ownership. Some states refer to certificate of need as determination of need. Many certificate of need laws require public hearings. When the department of health is determining whether to grant a certificate of need, it should consider whether the hospital provides, or plans to provide, community benefits. Unfortunately, not every state has a certificate

RESOURCE MATERIALS

of need law (35 states currently have certificate of need laws), and they vary from state to state. As a result, you should determine whether your state has a certificate of need law and, if so, what it governs.

- **Conversion legislation.** Twenty-six states have passed laws that specifically govern the conversion of nonprofit hospitals, HMOs, or insurers to for-profit. Although a few states have passed laws that collectively govern the conversion of nonprofit hospitals, HMOs, and insurers, most laws only govern the conversion of one type of healthcare entity (i.e., just hospitals). If your state has a conversion law, you should determine what it governs. While some of these laws specifically require an annual community benefits program, most do require public notice, hearings, and access to documents.
- **Corporation code.** Each state has a series of laws that govern how for-profit corporations operate; these laws are called the corporation code. In transactions that involve for-profit hospitals, HMOs, or insurers, the corporation code should be consulted. The corporation code will also tell you which transactions have public process provisions.
- **Insurance code.** Laws governing insurance companies and HMOs are found in the insurance code. It will contain provisions regarding mergers, acquisitions, and sales. The insurance code will also tell you which transactions have public process provisions.
- **Licensing laws, certificates of authority.** In all but one state,⁷⁷ hospitals must be licensed by the state department of health in order to function as a hospital. Similarly, HMOs and insurers must be licensed by the state department of insurance in order to conduct business. A license for an HMO or insurer is called a certificate of authority. New licenses are needed when there is a change in ownership, and licenses must often be renewed every few years. When granting licenses, the department of health or the department of insurance should consider whether the hospital, HMO, or insurer provides, or plans to provide, community benefits. Although no state currently requires community benefits as a condition of receiving a license, community benefits requirements could also potentially be placed in hospital, HMO, or insurer licensing laws. Licensing laws are currently very weak in terms of public process. While licensing applications will probably be considered public records (although this may vary from state to state), to our knowledge there are few, if any, public hearing requirements.
- **Nonprofit corporation code.** Each state has a series of laws that govern how nonprofit corporations operate; these laws are called the nonprofit corporation code. The nonprofit corporation code will also tell you which transactions have public process provisions.

77. Ohio is the only state that does not require hospitals to receive a license.

RESOURCE MATERIALS

- **Tax code.** Each state also has a series of laws and regulations that explain its tax system. These laws should have sections explaining tax exemption and what corporations must do in order to receive it. Community benefits requirements are sometimes located in the tax code.

NECESSARY DOCUMENTATION

- **Articles of incorporation and bylaws.** Every corporation must file articles of incorporation and bylaws when it becomes incorporated. In the case of nonprofit corporations, these documents will state the corporation's charitable purpose. These documents may be requested from the secretary of state's office in your state.
- **Financial statements for the past five years.** This information will allow you to determine what level of community benefits the corporation should be providing. These documents are public records, and as such, may be requested from the corporation.
- **Form A.** Insurers and HMOs that are engaged in a merger, sale, or conversion from nonprofit to for-profit file an application with the commissioner of insurance. Many states refer to this document as a Form A. It is important because it explains the terms of the transaction and provides background information on the companies involved in the transaction. It may also discuss community benefits. The Form A is a public record and may be requested from the commissioner of insurance after it is filed.
- **Form 990.** Tax-exempt organizations must file annual 990 forms with the Internal Revenue Service. These forms provide some basic information about how the institution is spending its money and are a good place to begin studying institutional finances. The 990 forms may contain information about the board of directors and the institution's community-giving practices. They also may help you to understand the institution's corporate structure. However, the documents are difficult to read, and it is advisable to consult with financial experts whenever possible. Under new IRS regulations, tax-exempt organizations must provide copies of their exemption applications and their three most recent 990s to anyone who requests this information. Organizations may make these documents available on their Web sites. Organizations that do not comply with these new requirements are subject to penalties of \$20 per day of violation to a maximum of \$10,000. See 64 Fed. Reg. 17, 279 (1999).
- **Internal hospital credit and collection policies.** You should learn and understand the hospital's internal policies regarding debt collection, including eligibility requirements for free care and sliding scale fees and information on how the hospital bills. For a better understanding of these policies, see page 102, "Free-Care Safety Net Fact Sheet."

E. Model Act*

The Healthcare Institution Responsibility Act

DIGEST

100. Legislative Findings; Intent

100.1 The legislature finds that access to healthcare services is of vital concern to the people of this state.

100.2 The legislature further finds that healthcare services providers play an important role in providing essential healthcare services in the communities they serve. In addition, insurers have become a dominant force affecting the provision of health care based on their ability to control reimbursement rates and make purchasing decisions on behalf of large patient populations. The legislature therefore also finds that insurers play an important role in providing essential healthcare services in the communities they serve.

100.3 Notwithstanding public and private efforts to increase access to health care, the people of this state continue to have tremendous unmet health needs. Studies suggest that as many as [number] or [percent] of the state’s residents are uninsured or underinsured.

100.4 The legislature further concludes that licensing privileges conveyed by this state to health care institutions for the right to conduct intrastate business should be accompanied by concomitant obligations to address unmet health care needs. These obligations should be clearly delineated.

100.5 The state has a substantial interest in assuring that the unmet health needs of its residents are addressed. Healthcare institutions can help address these needs by providing community benefits to the uninsured and underinsured members of their communities.

100.6 Community benefits should become a recognized and accepted obligation of all healthcare institutions in this state. Accordingly, every healthcare services provider that receives a license under section [cross reference with the health care services provider licensing section of the code] and every insurer that receives a certificate of authority under section [cross reference with the insurance certificate of authority section of the code] must provide community benefits in a manner set forth in this Act.

101 Definitions

101.1 As used in this Act, the following terms have the following meanings:

- a.** “Administration” means the [state] Insurance Administration.
- b.** “Bad debt” means the unpaid accounts of any individual who has received medical care or is financially responsible for the cost of care rendered to another, where such individual has the ability to pay, and has refused to pay.

* A commentary to this Model Act is available from Community Catalyst.

RESOURCE MATERIALS

- c. “Community” means the geographic service area(s) and patient population(s) that the healthcare institution serves.
- d. “Community benefits” means the unreimbursed goods, services, and resources provided by healthcare institutions that address community-identified health needs and concerns, particularly of those who are uninsured or underserved. Community benefits include but are not limited to the following:
 - 1. Free care;
 - 2. Public education and other programs relating to preventive medicine or the public health of the community;
 - 3. Health or disease screening programs;
 - 4. Free or below-cost prescription drugs;
 - 5. Transportation services;
 - 6. Poison control centers;
 - 7. Donated medical supplies and equipment;
 - 8. Unreimbursed costs of providing services to persons participating in any government-subsidized healthcare program;
 - 9. Free or below-cost blood banking services;
 - 10. Free or below-cost assistance, material, equipment, and training to EMS and ambulance services;
 - 11. The costs to implement a basic enrollment program that provides a package of primary-care services to uninsured members of the community; and
 - 12. Health research, education, and training programs, provided that they are related to identified community health needs.
- e. “Department” means the [state] Department of Health.
- f. “Free Care” means care provided by a healthcare services provider to patients unable to pay and for which the provider has no expectation of payment from the patient or from any third-party payer, and as further defined in §106 of this Act.
- g. “Healthcare Institution” means healthcare services providers and insurers jointly, as defined by this Act.
- h. “Healthcare Services Provider” has the meaning stated in section [] of the [state health code].

RESOURCE MATERIALS

- i. “Insurer” means an entity [under state code section] that pays for or arranges for the purchase of healthcare services provided by acute healthcare services providers. The term “insurer” shall not include [the state Medicaid program], other governmental programs of public assistance and their beneficiaries or recipients, and the workers compensation program established pursuant to [state code section or chapter].
- j. “Person” means any individual, partnership, corporation, association, joint venture, insurance company, or other organization.

102. Community Benefits; Basic Requirements

102.1 Each healthcare services provider that receives a license from this state shall provide community benefits to the community or communities it serves.

102.2 Each insurer that receives a certificate of authority from this state shall provide community benefits to the community or communities it serves.

102.3 Within 18 months from the day this Act is signed into law, each healthcare institution shall develop in collaboration with the community:

- a. An organizational mission statement that identifies the institution’s commitment to developing, adopting, and implementing a community benefits program;
- b. A description of the process for approval of the mission statement by the healthcare institution’s governing board;
- c. A declaration that senior management of the healthcare institution will be responsible for oversight and implementation of the community benefits plan;
- d. A community health assessment that evaluates the health needs and resources of the community it serves;
- e. A community benefits plan designed to achieve the following outcomes:
 - 1. increase access to healthcare for members of the target community or communities;
 - 2. address critical healthcare needs of members of the target community or communities; and
 - 3. foster measurable improvements in health for members of the target community or communities.

103. The Community Health Assessment

103.1 Prior to adopting a community benefits plan every healthcare institution subject to this Act shall identify and prioritize the health needs of the community it serves. It shall also identify health resources within the community. As part of the assessment, the healthcare institution shall solicit comment from and meet with community groups, local government officials, health related organizations, and healthcare providers, with particular attention given to those persons who are themselves underserved and those who work with underserved populations.

RESOURCE MATERIALS

- 103.2** The Department shall compile available public health data, including statistics on the state's unmet healthcare needs. In preparing its community health assessment, a healthcare institution shall use available public health data.
- 103.3** Healthcare institutions are encouraged to collaborate with other healthcare institutions in conducting community health assessments and may make use of existing studies and plans in completing their own community health assessments.
- 103.4** Prior to finalizing the community health assessment, each health care institution shall make available to the public a copy of the community health assessment for review and comment.
- 103.5** Once finalized, the community health assessment shall be updated at least every three years.
- 104. The Community Benefits Plan**
- 104.1** Every healthcare institution shall adopt, annually, a plan for providing community benefits.
- 104.2** The community benefits plan shall be drafted with input from the community as provided for in Section 103.1 of this Act.
- 104.3** The community benefits plan shall include, at a minimum:
- a.** a list of the services the healthcare institution intends to provide in the following year to address community health needs identified in the community health assessment. The list of services shall be categorized under:
 - 1.** Free care;
 - 2.** Other services for vulnerable populations;
 - 3.** Health research, education, and training programs;
 - 4.** Community benefits that address public health needs; and
 - 5.** Nonquantifiable services, such as local governance and preferential hiring policies that benefit those who are uninsured or underserved.
 - b.** a description of the target community or communities that the plan is intended to benefit;
 - c.** an estimate of the economic value of the community benefits that the healthcare entity intends to provide under the plan;
 - d.** a report summarizing the process used to elicit community participation in the community health assessment and community benefits plan design, and ongoing implementation and oversight;
 - e.** a list of individuals, organizations, and government officials consulted during development of the plan and a description of any provisions made for the promotion of ongoing participation by community members in the implementation of the plan;

RESOURCE MATERIALS

- f. a statement identifying the healthcare needs of the communities that were considered in developing the plan;
- g. a statement describing the intended impact on health outcomes attributable to the plan, including short- and long-term measurable goals and objectives;
- h. mechanisms to evaluate the plan's effectiveness, including a method for soliciting comments by community members; and
- i. the name and title of the person who shall be responsible for implementing the community benefits plan.

104.4 Each healthcare services provider shall submit its community benefits plan to the Department prior to implementation.

104.5 Each healthcare services provider shall make its community benefits plan available to the public for review and comment prior to implementation.

104.6 Each insurer shall submit its community benefits plan to the Administration prior to implementation.

104.7 Each insurer shall make its community benefits plan available to the public for review and comment prior to implementation.

105. Annual Report

105.1 Within 120 days of the end of the healthcare services provider's fiscal year, each healthcare services provider shall submit to the Department an annual report detailing its community benefits efforts in the preceding calendar year. The annual report shall include:

- a. the healthcare services provider's mission statement;
- b. the amounts and types of community benefits provided, listed in categories provided in §104.3(a), provided on a form to be developed by the Department;
- c. a statement of the healthcare services provider's impact on health outcomes attributable to the plan, including a description of the healthcare services provider's progress toward meeting its short- and long-term goals and objectives;
- d. an evaluation of the plan's effectiveness, including a description of the method by which community members' comments have been solicited; and
- e. the healthcare services provider's audited financial statement.

105.2 Each healthcare services provider shall prepare a statement announcing that its annual community benefits report is available to the public. The statement shall be posted in prominent locations throughout the healthcare services provider's facility, including the emergency room waiting area, the admissions waiting area, and the business office. The statement shall also be included in any written material that discusses the admissions or free-care criteria of the healthcare services provider. A copy of the report shall be given free of charge to anyone who requests it.

RESOURCE MATERIALS

- 105.3** Information provided in accordance with §105.1(b) shall be calculated in accordance with generally accepted accounting standards. This information shall be calculated for each individual healthcare services provider within a system and not on an aggregate basis, though both calculations may be submitted. Each healthcare services provider shall also file a calculation of its cost-to-charge ratio with its annual report.
- 105.4** Within 120 days of the end of the insurer's fiscal year, each insurer shall submit to the Administration an annual report detailing its community benefits efforts in the preceding calendar year. The annual report shall include:
- a.** the insurer's mission statement;
 - b.** the amounts and types of community benefits provided, listed in categories provided in §104.3(a), provided on a form to be developed by the Administration;
 - c.** a statement of the insurer's impact on health outcomes attributable to the plan, including a description of the insurer's progress toward meeting its short- and long-term goals and objectives;
 - d.** an evaluation of the plan's effectiveness, including a description of the method by which community members' comments have been solicited; and
 - e.** the insurer's audited financial statement.
- 105.5** Each insurer shall prepare a statement announcing that its annual community benefits report is available to the public. The statement shall be posted in the insurer's business offices. The statement shall also be mailed to each subscriber. A copy of the report shall be given free of charge to anyone who requests it.
- 105.6** Information provided in accordance with §105.4(b) shall be calculated in accordance with generally accepted accounting standards. This information shall be calculated for each individual insurer within a system and not on an aggregate basis, though both calculations may be submitted. Each insurer shall also file a calculation of its cost-to-charge ratio with its annual report.
- 105.7** Any person who disagrees with a community benefits report may file a dissenting report with the Department or with the Administration, as appropriate. Dissenting reports shall be filed within 60 days of the filing of the community benefits report and shall become public records.
- 106. Free Care**
- 106.1** Every healthcare services provider that provides free care in full or partial fulfillment of its community benefits obligation shall develop a written notice describing its free-care program and explaining how to apply for free care. The notice shall be in appropriate languages and conspicuously posted throughout the healthcare services provider facility, including the general waiting area, the emergency room waiting area, and the business office.

RESOURCE MATERIALS

106.2 Every healthcare services provider that provides free care in full or partial fulfillment of its community benefits obligation shall report the value of such care, provided that the value of such care does not include any bad debt costs.

107. Subsidized Care; Sliding Scale Fees

107.1 In determining sliding scale fees or other payment schedules for uninsured persons, healthcare services providers should base such fees on the income of the uninsured person.

107.2 Where the sliding scale fee is below actual costs, the healthcare services provider may include the difference in its community benefits computation.

108. Monitoring and Enforcement of Healthcare Services Provider Community Benefits

108.1 The Department shall assess a penalty of not less than \$1000/day against any healthcare services provider that fails to file a community benefits plan or a timely annual community benefits report.

108.2 The Department shall revoke or decline to renew the license of any healthcare services provider that fails to provide community benefits as required by this Act. The Department may issue a provisional license for a period of up to one year to any healthcare services provider that has had its license revoked or non-renewed.

108.3 Before taking any punitive action, the Department must hold an adjudicative hearing, giving the affected parties at least 14 days notice. Any person who filed a dissenting report has standing to testify at the hearing. Any punitive measures taken by the Department following the hearing shall be considered final action for purposes of appeal.

108.4 Any final action by the Department shall be subject to judicial review by the state superior court at the initiation of any person who participated in the adjudicative hearing.

108.5 The Department shall submit a report to the Legislature on September 1 of each year that contains the following:

- a.** The name of each healthcare services provider, if any, that did not file a community benefits report in the preceding year;
- b.** The name of each person who filed a dissenting report, and the substance of the complaint;
- c.** A list of the most common activities performed by healthcare services providers in fulfillment of their community benefits obligation;
- d.** The dollar value of the community benefits activities performed by healthcare services providers, expressed in both aggregate and individual terms; and
- e.** The amount of net patient revenue for each healthcare services provider.

RESOURCE MATERIALS

- 108.6** The report referred to in section 108.5 of this Act shall be available to the public.
- 108.7** The Department shall promulgate rules and regulations necessary to effectuate this Act.
- 109. Monitoring and Enforcement of Insurer Community Benefits**
- 109.1** The Administration shall assess a penalty of not less than \$1000/day against any insurer that fails to file a community benefits plan or a timely annual community benefits report.
- 109.2** The Administration shall revoke or decline to renew the certificate of authority of any insurer that fails to provide community benefits as required by this Act. The Administration may issue a provisional certificate of authority for a period of up to one year to any insurer that has had its certificate of authority revoked or nonrenewed.
- 109.3** Before taking any punitive action, the Administration must hold an adjudicative hearing, giving the affected parties at least 14 days notice. Any person who filed a dissenting report has standing to testify at the hearing. Any punitive measures taken by the Administration following the hearing shall be considered final action for purposes of appeal.
- 109.4** Any final action by the Administration shall be subject to judicial review by the state superior court at the initiation of any person who participated in the adjudicative hearing.
- 109.5** The Administration shall submit a report to the Legislature on September 1 of each year that contains the following:
- a.** The name of each insurer, if any, that did not file a community benefits report in the preceding year;
 - b.** The name of each person who filed a dissenting report, and the substance of the complaint;
 - c.** A list of the most common activities performed by insurers in fulfillment of their community benefits obligation;
 - d.** The dollar value of the community benefits performed by insurers, expressed in both aggregate and individual terms; and
 - e.** The amount of net premium revenue for each insurer.
- 109.6** The report referred to in section 109.5 of this Act shall be available to the public.
- 109.7** The Administration shall promulgate rules and regulations necessary to effectuate this Act

F. Excerpts from the Catholic Health Association Social Accountability Budget

Calculation of Ratio of Patient Costs to Charges

PERIOD OF ANALYSIS	BUDGET 1990
I. Adjusted Total Operating Expenses	
A. Total operating expenses	\$38,500,000*
B. Less: adjustments	
1. Cost for nonbilled services	700,000
2. Medicare program costs	19,500,000
3. Education/research expenses	1,000,000
4. Fund-raising expenses/other	<u>425,000</u>
Total adjustments	<u>21,625,000</u>
Adjusted total operating expenses	<u>\$16,875,000</u>
II. Adjusted Total Patient Charges	
A. Total patient service revenue	\$50,000,000
B. Less: adjustments	
1. Medicare program charges	26,000,000
2. Other charges	<u>0</u>
Total adjustments	<u>26,000,000</u>
Adjusted total patient revenue	<u>\$24,000,000</u>
III. Ratio Calculation	
A. Adjusted total operating expenses	\$16,875,000
B. Adjusted total patient revenue	\$24,000,000
Calculated ratio = A/B = (applied to total patient charges)	<u>70.31%</u>
<p>* Some have argued that this figure should be increased by 4 to 5 percent to account for financial needs not included in operating expense number, such as working capital, preservation of purchasing power of capital invested in plant, plant expansion, and contingencies. This is certainly a defensible addition to the formula, although you should be explicit in explaining that a “plus factor” for these financial needs has been included.</p> <p>Source: Excerpted with permission from the Catholic Health Association Social Accountability Budget.</p>	

Unpaid Costs of Public Programs*

PERIOD OF ANALYSIS	BUDGET 1990			
	Benefits for the Poor			Broader Community Benefits
	Medicaid	All Other	Total	Medicare
Patient volumes				
Inpatient cases (discharges)	500	240	740	2,360
Inpatient days	2,000	1,200	3,200	20,000
Outpatient visits	6,000	4,000	10,000	40,000
Charges				
Inpatient	\$1,600,000	\$960,000	\$2,560,000	20,000,000
Outpatient	<u>720,000</u>	<u>480,000</u>	<u>1,200,000</u>	<u>6,000,000</u>
Total	<u>\$2,320,000</u>	<u>\$1,440,000</u>	<u>\$3,760,000</u>	<u>\$26,000,000</u>
Reimbursement and other support				
Inpatient	800,000	540,000	1,340,000	13,500,000
Outpatient	<u>360,000</u>	<u>240,000</u>	<u>600,000</u>	<u>4,500,000</u>
Total	<u>\$1,160,000</u>	<u>\$ 780,000</u>	<u>\$1,940,000</u>	<u>\$18,000,000</u>
Estimated expenses				
Ratio of costs to charges	70.31%	70.31%	—	N/A
Total expenses	<u>\$1,631,250</u>	<u>\$1,012,500</u>	<u>\$2,643,750</u>	<u>\$19,500,000*</u>
Un-sponsored expenses	<u>\$ 471,250</u>	<u>\$ 232,500</u>	<u>\$ 703,750</u>	<u>\$ 1,500,000</u>

* From Medicare cost report or from other cost accounting information as appropriate, such as overall ratio of costs to charges.
 Source: Excerpted with permission from the Catholic Health Association Social Accountability Budget.

Summary Analysis of All Nonbilled Services/Costs*

PERIOD OF ANALYSIS	BUDGET 1990		
	Services and Programs for		
	The Poor	The General Community	The Total Community
Number of services and activities	12	8	20
Units of service (patients served)	800	600	1,400
Encounters	1,600	1,200	2,800
Total community benefit expense	\$400,000	\$300,000	\$700,000
Identifiable funding for nonbilled services	<u>\$100,000</u>	<u>\$ 50,000</u>	<u>\$150,000</u>
Un-sponsored community benefit expenses	<u>\$300,000</u>	<u>\$250,000</u>	<u>\$550,000</u>

* Source: Excerpted with permission from the Catholic Health Association Social Accountability Budget.

Estimated Costs of Fund-Raising*

PERIOD OF ANALYSIS	BUDGET 1990	
1. Apportionment of contributions		
a. Charitable activities	\$ 500,000	50.0%
b. Other community benefits	300,000	30.0%
c. All other contributions	<u>200,000</u>	20.0%
Total contributions	<u>\$1,000,000</u>	100.0%
2. Calculation of fund-raising expenses for community benefits and charity	\$250,000	
Total fund-raising expenses		
Percentage allocation of expenses		
Benefits for the poor		50.0%
Benefits for the broader community		30.0%
Allocation of expenses		
Benefits for the poor	\$125,000	
Benefits for the broader community	\$ 75,000	

* Source: Excerpted with permission from the Catholic Health Association Social Accountability Budget.

G. Other Helpful Materials Available on Community Benefits

- The Access Project, Fact Sheet: Defending Community Benefits in a Changing Health Care World (February 1999).
- The Access Project, How Many Uninsured? A Resource Guide for Community Estimates (June, 1999).
- Kevin Barnett, The Future of Community Benefit Programming (1997).
The Public Health Institute, Berkeley, CA. (510) 644-9300.
- The Catholic Health Association of the United States, Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint, (1989).
- Coalition for Nonprofit Health Care, Redefining the Community Benefit Standard: State Law Approaches to Ensuring the Social Accountability of Nonprofit Health Care Organizations (July 1999).
- Community Catalyst, “Boston at Risk 2000: Facilitator Manual” and “Boston at Risk 2000: Six Principles for a New Health Care System: A Blueprint for Action” (October, 1994)
- Community Catalyst, Health Care Institution Model Act and Commentary (December 1999).
- Community Catalyst, Community Benefits in a Changing Health Care Market, States of Health, Vol. 7, No. 5 (July 1997).
- Community Catalyst, Compendium of State Community Benefits Laws, Regulations and Guidelines (November 1999).
- Alan Sager et. al, Before It’s Too Late. Why Hospital Closings Are a Problem, Not a Solution (June 2, 1997, 2nd ed.). Available by request at asager@bu.edu.
- Mark Schlesinger and Bradford Gray, A Broader Vision for Managed Care, Part I: Measuring the Benefit to Communities, *Health Affairs* (May/June 1998) 152-168.
- Mark Schlesinger et. al, A Broader Vision for Managed Care, Part II: A Typology of Community Benefits, *Health Affairs* (September/October 1998) 26-49.

CONTACT INFORMATION

Contact Information for Groups Cited in Community Benefits Manual

Boston Health Access Project

c/o Health Care For All
30 Winter Street, 10th Floor
Boston, MA 02108
(617) 350-7279
Fax: (617) 451-5838

Brockton Interfaith Community

65 West Elm Street
Brockton, MA 02401
(508) 587-9550
Fax: (508) 587-9550

Building Parent Power

13 Enfield Street
Hartford, CT 06112
(860) 527-6569
Fax: (860) 527-6534

Cambridge Health Alliance

1493 Cambridge Street
Cambridge, MA 02139
(617) 665-1002
Fax: (617) 665-1003

Central Massachusetts Community Health Coalition

360 West Boylston Street
West Boylston, MA 01583
(508) 852-5539
Fax: (508) 852-5425

Community Catalyst

30 Winter Street, 10th Floor
Boston, MA 02108
(617) 338-6035
Fax: (617) 451-5838

Health Care For All

30 Winter Street, 10th Floor
Boston, MA 02108
(617) 350-7279
Fax: (617) 451-5838

Health Law Advocates

30 Winter Street, 9th Floor
Boston, MA 02108
(617) 338-5241
Fax: (617) 338-5242

Idaho Community Action Network

1311 West Jefferson Street
Boise, ID 83702
(208) 385-9146
Fax: (208) 336-0339

Illinois Campaign for Better Health Care

44 E. Main Street, #414
Champaign, IL 61820
(217) 352-5600
Fax: (217) 352-5688

Local 1199, Northwest, SEIU

221 First Avenue West, Suite 212
Seattle, WA 98119
(206) 283-1199
Fax: (206) 283-3459

CONTACT INFORMATION

Lynn Health Task Force

c/o Neighborhood Legal Services
37 Friend Street
Lynn, MA 01902
(781) 599-7730
Fax: (781) 595-2002

Maine Consumers for Affordable Health Care

P.O. Box 2490
One Weston Court, level one
Augusta, ME 04338-2490
(207) 622-7045
Fax: (207) 622-7077

Maine People's Alliance

27 State Street, Suite 44
Bangor, ME 04401-5113
(207) 990-0672
Fax: (207) 990-0772

New Hampshire Minority Health Coalition

P. O. Box 3992
1415 Elm Street, 2nd Floor
Manchester, NH 03105
(603) 627-7703
Fax: (603) 627-7703

Neponset Valley Community Health Coalition

Norwood Town Hall
P.O. Box 40
Norwood, MA 02062
(781) 762-1240
Fax: (781) 762-9180

Northwest Federation of Community Organizations

1905 South Jackson Street
Seattle, WA 98144
(206) 568-5400
Fax: (206) 568-5444

Oregon Health Action Campaign

3896 Beverly Avenue NE, #J-6
Salem, OR 97305
(503) 581-6830
Fax: (503) 370-7630

Pajaro Valley Coalition To Save Community Health Care

204 East Beach Street
Watsonville, CA 95076
(831) 763-3401
Fax: (831) 728-8266

Universal Health Care Action Network—Ohio

1015 E. Main St., Room 302
Columbus, Ohio 43205
(614) 253-4340
Fax: (614) 253-4339

Washington Citizen Action

100 South King Street
Seattle, WA 98104
(206) 389-0050
Fax: (206) 389-0049

About the Authors

The Access Project would like to thank the authors, Natalie Seto and Bess Karger Weiskopf, for developing this manual. In their work at Community Catalyst, they have garnered broad experience and provided counsel to many communities on issues related to healthcare restructuring and community benefits through two national projects: *The Community Benefit Initiative* and *The Community Health Assets Project*. These projects provide policy, legal, strategic, and other technical support to community coalitions, regulators, legislators, and the media nationwide.

Natalie A. Seto was the director of *The Community Benefit Initiative*, *The Community Health Assets Project*, and *The New England Action in Health Law Project*. Ms. Seto is also an author of many papers, publications, and community training tools relating to healthcare restructurings and community benefits. Previously, Ms. Seto worked at Health Care For All, a Massachusetts consumer rights organization, where she helped to develop consumer leadership and community-based coalitions. Ms. Seto has an undergraduate degree from Miami University and a J.D. from Boston College School of Law.

Bess Karger Weiskopf is a staff attorney at Community Catalyst where she works on *The Community Benefit Initiative* and *The Community Health Assets Project*. She is an author of several papers and community training tools relating to healthcare restructuring, and community benefits. Ms. Weiskopf continues to monitor state legislation on conversions and community benefits, maintaining an up-to-date clearinghouse of this information including comparative analysis charts of these laws. Ms. Weiskopf has an undergraduate degree from Brandeis University and a J.D. from Northeastern University School of Law.

Ms. Seto and Ms. Weiskopf previously collaborated and authored “Protecting Health, Preserving Assets: A Comprehensive Study of Laws Governing Conversion, Mergers, and Acquisitions Among Health Care Entities,” published in *Clearinghouse Review*.

Index

A

Access Project, v, 102n
Access to health care, 86
Accountability
 in community benefits plan, 29
 for free care, 104
 institutional, xii
Action plans, 18–19, 65–66
Allies, 75–76
Anderson, J. Kendall, 15n
Angell, Marcia, 84n
Annual report, 28, 115–116
Articles of incorporation and bylaws, 110
Assessment of health needs, 24–25, 53, 113–114
Assistance, responding to calls for, 50
Attorney general, 108
Authority, certificates of, 110, 117

B

Bad debt
 defined, 104, 111
 free care vs., 104–105
Banks, community responsibilities of, 15, 17
Barnett, Kevin, 23n
Behavior, institutional, 65
Beneficiaries of community benefits plan, 25–28
Benefits. *See* Community benefits
Blue Cross and Blue Shield plans, 19
Board meetings, 8
Bobo, Kim, 36
Boston at Risk 2000, 4n
Boston Health Access Project (BHAP), 68, 123
Boutique hospitals, 13, 19
Brockton Interfaith Community (BIC), 39, 53, 123
Budget, 28, 119–121
 fund raising costs, 119
 nonbilled services and costs in, 121
 ratio of patient costs to charges in, 119
 sample, 119–121
 unpaid costs in, 120
Building Parent Power (BPP), 58, 123
Bylaws, 109

C

Cambridge City Hospital (Cambridge, Mass.), 67
Cambridge Department of Health (Cambridge, Mass.), 67
Cambridge (Massachusetts) Health Alliance, 56, 123
Canvassing, 43–44
Caritas Christi Health Care System, 21
Catholic Health Association, 23
 Social Accountability Budget, 119–121
Central Massachusetts Community Health Coalition (CMHC), 62, 123
Certificate of authority, 109, 118
Certificate of need laws, 94, 108
Charges
 costs vs., 104–106, 119
 sliding scale fees, 117
Cholesterol screening, as unreimbursed service, 12
Circumstances, considering, 72–76
Civil Rights Act, 11
Collection policies, 110
Collins, Karen Scott, 86n
Commissioner of corporations, 108
Commissioner of health, 108
Commissioner of insurance, 108
Communication, 73
Community
 advancing interests of, xii
 communication with institution, 73
 defined, 2, 111
 first meeting with, 77–78
 organizing. *See* Organizing
Community benefits
 activities not qualifying as, 12
 basic requirements for, 113
 concept of, x
 defined, 2, 23, 112
 developing group's definition of, 21–22
 evaluating, 5–12
 evaluating importance of, 83–91
 institutional responsibility for, 13–31, 95–100, 102–106, 111–118
 law on, x, 23, 67–68, 107

INDEX

- Community benefits (*continued*)
limits of, xi
nonprofit hospitals and, x, 13, 15–16, 96, 102
questionable claims, 5
“true,” 6–12
- Community Benefit Guidelines for Health Maintenance Organizations, 17, 94
- Community Benefit Guidelines for Nonprofit Acute Care Hospitals, 28n, 94
- Community benefits plan, 25–30
annual report, 28, 115–116
baseline standard for contribution, 31
beneficiaries of, 25–28
budget in, 27, 119–121
enforcement of, 29–30, 117–118
evaluation of, 28–30
law on, 114–115
mission statement of, 26
monitoring of, 117–118
- Community benefits policy roundtable, 10
- Community Benefits Advisory Group, 28n
- Community Benefits Model Act, xin
- Community Care Network, 37
- Community Catalyst, v, 17n, 90n, 111n, 123
- Community-created events, 63–68
- Community forums, 51–52
- Community Health Systems (CHS), 62–63
- Community-identified health needs and concerns, 2
- Community leaders
developing, 56–57
dual and shifting roles of, 68–69
free care and, 104
health care institutions as, 65–66
interview questions for, 45
- Community organizations
building, 57–59
goals of, 69–71, 72
interview questions for, 45
- Community Reinvestment Act, 17, 95n
- Community-wide policy-making arena, 70
- Consolidations
changes in health care system and, ix, x
community vigilance and, 13
- Constituencies
engaging, 35–36
identifying, 34–35, 37
linking for power, 64
- Consumers for Affordable Health Care Foundation, 47–49
- Contact information, 123–124
- Contribution, baseline standard for, 31
- Conversations, one-on-one, 41–42
- Conversion laws, 17–18, 108–109, 110
- Costs
charges vs., 105–106, 119
of fund raising, 121
of health care, 84–85, 90
of pharmaceuticals, 87–88
unpaid, 120
- Covington, Sally, 36
- Credit policies, 110
- D**
- Deaconess Incarnate World Health System (DIWHS), 18
- Debt. *See* Bad debt
- Decision-making process, levels of involvement in, 58
- Deol, Jasprit, 13n
- Determination of Need process, 21
- Documentation, 110
- Doorknocking, 43–44, 65
- Drug costs, 87–88, 89
- E**
- Education, as community benefit, 9
- Eisenberg, Pablo, 36
- Emergency room, as community benefit, 10
- Enforcement, of community benefits plan, 29–30, 117–118
- Engaging, 35–36
- Evaluation
of community benefits activity, 5–12
of community benefits plan, 28–29
of importance of community benefits issue, 83–90
- Exercises. *See* Group exercises
- Expenditures, 84–85
- External events, 62–63
- F**
- Fee(s). *See* Charges
- Feedback form, 129
- Fiduciary responsibility, 100
- Financial statements, 110
- First meetings, 77–78
- Food and Drug Administration, 87
- Form A, 110
- Form 990, 110
- For-profit health care institutions
boutique (niche), 13, 18

INDEX

- changes in health care system and, ix, x
- community obligations of, 16–17, 95–96, 102–104
- conversion of nonprofit institutions to, 17–18, 109, 110
- nonhospital-based, 18–19
- See also* Health care institutions
- Forums, community, 51–52
- Free care, 31–32, 102–106
 - accountability for, 104
 - bad debt vs., 104–105
 - defined, 102, 112
 - improving, 104
 - law on, 116–117
 - obligation to provide, 102
 - policy on, 103, 106
 - problems in getting, 102–103
- Free care campaign, 65
- Free Care Pool (Massachusetts), 16, 18
- Free Care Safety Net Fact Sheet, 102–106
- Fund-raising costs, 121
- G**
- Goals, 69–71, 72
- Goods and services. *See* Unreimbursed goods and services
- Group exercises
 - on allies list, 76
 - on developing group's definition of community benefits, 22
 - on factors contributing to health, 4–5
 - on identifying goals, 71
 - on identifying participants, 37
 - on negotiation, 81
 - on responsibility for community benefits, 14
 - on “true” community benefits, 6–7
- H**
- Haas, Gilda, 36
- Harshbarger, Scott, 17, 23n
- Hattis, Paul, 23n
- Health
 - basic factors in, 90
 - commissioner of, 108
 - factors contributing to, 4–5
 - health care costs vs., 90
 - health care vs., 3–5
- Health care
 - access to, 86
 - committees studying, 9
 - cost of, vs. health, 90
 - expenditures on, 84–85, 89
 - health vs., 2–5
 - quality of, 86–87
 - “social good” view of, 16
 - subsidized, 117
 - uncompensated, 104–105
- Health Care For All (HCFAMA), vi, 19n, 50n, 68, 123
- Health care institutions
 - accountability of, xii–xiii, 29, 104
 - challenging behavior of, 65
 - communication with community, 73
 - as community leaders, 66
 - defined, 2, 112
 - first meeting with, 72
 - free care policy of, 103, 106
 - internal credit and collection policies of, 110
 - interview questions for, 46
 - licensing of, 20, 109, 117
 - mission statement of, 73
 - monitoring and enforcement of community benefits, 117–118
 - perceptions of, 73
 - perspective of, 74–75
 - responsibility for community benefits, 13–32, 95–101, 102, 111–118
 - restructuring of, 62–63
 - structure and finances of, 74
 - teaching institutions, 97
 - understanding current community benefits activity of, 74
 - See also* For-profit health care institutions; Nonprofit health care institutions
- Health Care Services Provider, 112
- Health care system, changes in, ix–x
- Health Institution Responsibility Model Act, xin
- Health Insurance Portability and Accountability Act (HIPAA), 98–99
- Health Law Advocates, 123
- Health maintenance organizations (HMOs)
 - changes in health care system and, ix–x
 - community obligations of, 16–17, 97–98
 - as “insurer of last resort,” 98–99
- Health needs and concerns
 - assessment of, 24, 53, 113–114
 - board meetings on, 8
 - community-identified, 2
 - survey on, 47–49
- History, knowing, 73–74
- HMOs. *See* Health maintenance organizations (HMOs)

INDEX

- Hospitals
boutique (niche), 13, 18
for-profit. *See* For-profit health care institutions
free care policy of, 103, 106
internal credit and collection policies of, 110
legal definition of, 10
licensing of, 20, 109, 117
minorities and, 13
nonprofit. *See* Nonprofit health care institutions
tax exemptions of, 63, 74n, 110
See also Health care institutions
- Hospital service plans, community obligations of, 19
- House meetings, 40
- I**
- Idaho Community Action Network (ICAN), 43–44, 65, 123
- Illinois Campaign for Better Health Care, 64, 123
- Incorporation, articles of, 110
- Institution(s). *See* Health care institutions
- Institutional policy-making arena, 69
- Institutions of Purely Public Charity Act (Pennsylvania), 16
- Insurance
commissioner of, 108
costs of, 85
- Insurance code, 109
- Insurance companies
community benefits and, 97–99
community obligations of, 18–19
monitoring and enforcement of community benefits, 118
- Insurer, defined, 113
- “Insurer of last resort,” 98–99, 113
- Interests of community, advancing, xii
- Internal Revenue Service, 74n, 110
- Interpreter services, as community benefit, 11
- Interviews, 44
- J**
- Jamaica Plain Community Benefits Group, 68
- Judicial review, 118
- K**
- Kellogg Foundation, 23, 35
- Kendall, Jackie, 36
- Kennedy-Kassebaum Act, 98–99
- Key-informant interviews, 44
- King County (Washington) Health Action Plan, 66
- Kurland, Judith, 68
- Kuttner, Robert, 86n
- L**
- Law(s), 94, 108–109
certificate of need, 94, 108
on community benefits plan, 27n, 28n, 29n, 30n, 31n, 114–115
on community benefits, x, 23, 67–68, 107
on community health needs assessment, 24n, 113–115
on conversion of nonprofit health care institutions to for-profit status, 17–18, 109, 110
on definition of hospital, 10
on free care, 116–117
on institutional responsibility, 15, 16, 17, 111–118
on “insurers of last resort,” 98–99, 113
on interpreter services, 11
on licensing, 20, 109, 117
- Model Acts, xiii, 111–118
on nonhospital-based entities, 18–19
on unreimbursed goods and services, 12
See also specific laws
- Leaders. *See* Community leaders
- Levit, Katharine, 87n
- Licensing, 20, 109, 117
- Long-term goals, 69, 72
- Lynn Health Task Force, 51–52, 124
- M**
- Maine Consumers for Affordable Health Care (MCAHC), 47–49, 124
- Maine People’s Alliance, 43, 64, 124
- Managed care
changes in health care system and, ix, x
quality of health care and, 87
- Mateo, Julio, Jr., 16n, 86n
- Max, Steve, 36
- Medicaid patients
drug coverage for, 88
expenditures on, 84, 85
nonprofit hospitals and, 96
reimbursement for treating, 12
uncompensated care for, 105
- Medical education, as community benefit, 9
- Medical research, as community benefit, 9
- Medicare
drug coverage by, 88
expenditures for, 85
uncompensated care and, 105

INDEX

- Meetings
 - of board, 8
 - first, 77–78
 - house, 40
- Membership development, 56–57
- Mendoza, Gary, 15n
- Mercy Hospital (Portland, Me.), 63
- Mergers, and changes in health care system, ix, x, 110
- Minorities, and hospital closings, 13
- Mission statement
 - of community benefits plan, 26
 - of health care institution, 73
- Model Acts, xin, 111–118
- N**
- Nadeau, Denise, 36
- National Center for Health Statistics, 84n
- National Health Statistics Group, 85n
- Need(s)
 - certificate of, 94, 108
 - Determination of, 21
 - See also* Health needs and concerns
- Negotiation, 78–81
- Neighborhoods, linking for power, 64
- Neponset Valley Community Health System (NVHS), 21, 124
- Networks, community, 38–40
- New Hampshire Minority Health Coalition, 124
- Niche hospitals, 13
- Nonhospital-based entities, community obligations of, 18–19
- Nonprofit corporation code, 109
- Nonprofit health care institutions
 - community obligations of, x, 13, 15–16, 96, 102
 - conversion to for-profit status, 17–18, 109, 110
 - nonhospital-based, 18–19
 - See also* Health care institutions
- Nonprofit Hospital and Nursing Home Charitable Property Tax Exemption Standards, 18–19, 94
- Northwest Federation of Community Organizations, 6n, 124
- O**
- Oleck, Howard, 15n
- One-to-one relationships, building, 41–44
- Open house, as community benefit, 10
- Opportunities, organizing, 62–68, 107
- Oregon Health Action Campaign (OHAC), 45–46, 124
- Organization(s). *See* Community organizations; Health maintenance organizations (HMOs)
- Organization, Leadership, and Training Center (Dorchester, Mass.), 40n, 41n
- Organizing, 33–59
 - building strong community organizations, 57–59
 - creating an outreach work plan for, 54–55
 - identifying and engaging participants, 34–37
 - membership development and, 56–57
 - techniques for, 38–54
- OrNda Healthcorp, 62
- Outpatient surgical centers, community obligations of, 18
- Outreach and organizing techniques, 38–54
 - building community networks, 38–40
 - building one-on-one relationships, 41–44
 - conducting community needs assessments, 53
 - convening community forums, 51–52
 - interviews, 45
 - questionnaires and surveys, 47–49
 - responding to calls for assistance, 50
 - utilizing research, 53
- Outreach work plan, 54–55
- P**
- Pajaro Valley Coalition to Save Community Health Care, 62–63, 124
- Parachini, Larry, 36
- Participants
 - engaging, 35
 - identifying, 34–35, 37
- Perkins, Jane, 11n
- Perspective, institutional, 74–75
- Pharmaceutical companies, community obligations of, 20
- Pharmaceutical costs, 87–88, 89
- Physician groups, community obligations of, 19
- Policy goals, 69
- Policy-making arenas, 70
- Power, linking neighborhoods and constituencies for, 64
- Prescription drugs, 87–88, 89
- Privatization, and changes in health care system, x
- Public hearings, in establishing institutional responsibility, 20
- Q**
- Quality of health care, 86–87
- Question(s), how to handle, 95–101
- Questionnaires, 47–49

INDEX

R

- Recreation program, as community benefit, 11
- Regulators, 108
- Regulatory oversight, 107. *See also* Law(s); specific laws
- Research
 - as community benefit, 9
 - utilizing for organizing and outreach, 53
- Resource materials, 93–124
 - Catholic Health Association Social Accountability Budget, 119–121
 - community benefits laws, regulations, and guidelines, 94
 - contact information, 123–124
 - documentation, 110
 - Free Care Safety Net Fact Sheet, 102–106
 - laws, 108–109
 - Model Act, 111–118
 - organizing opportunities, 107
 - regulators, 108
 - suggested handling of tough questions, 95–101
- Responsibilities, 13–32
 - fiduciary, 100
 - of for-profit institutions, 16–17, 95–96, 102
 - law on, 15, 111–118
 - of nonprofit hospitals, x, 13, 15–16, 96, 102
 - for uninsured people, 100, 102–103
- Restructuring, 62–63
- Roger Williams Hospital (Rhode Island), 73
- Roles, shifts in, 68–69
- Rosenbach, Margo L., xii
- Rossi, Jaime, 16n, 86n

S

- Sager, Alan, 13, 86n
- St. Elizabeth's Medical Center, 26
- St. Luke's Hospital (Boise, Idaho), 65
- St. Vincent Healthcare System, 62
- Schlesinger, Mark, 23n
- Schulman, Kevin A., 87n
- Scripts, for canvassing, 43–44
- Seattle–King County (Washington) Department of Public Health, 66
- Service Employees International Union 1199, Northwest, 66, 123
- Short-term goals, 69, 72
- Sliding scale fees, 117

- Socolar, Deborah, 13n
- Somerville Hospital (Somerville, Mass.), 67
- “Speak-outs,” 51–52
- Staples, Lee, 36
- State-wide policy-making arena, 70
- Steering Committee, 66
- Strategic approach, 61–81
 - clarifying goals, 69–71
 - considering circumstances, 72–76
 - first meetings, 77–78
 - negotiating, 78–81
 - recognizing dual and shifting roles, 68–69
 - seeing and creating opportunities, 62–69
- Subsidized care, 117
- Support system, and membership development, 56–57
- Surveys, 47–49
- Symphony, support for, as community benefit, 8

T

- Tax code, 109
- Tax exemptions, 63, 74n, 110
- Teaching institutions, 97
- Tenet Healthcare Corporation, 18, 62
- Translation services, 11

U

- Uncompensated care, 104–105
- Uninsured people, 100, 102–103
- Universal Health Care Action Network of Ohio (UHCAN-Ohio), 39, 124
- Unpaid costs, 120
- Unreimbursed goods and services
 - as community benefit, 12
 - defined, 2
 - law on, 12

W

- Washington Citizen Action, 66, 124
- Watsonville Community Hospital, 62–63
- Wong, Kent, 36
- Work plan for outreach, 54–55

Y

- Youth recreation program, as community benefit, 11

